

Research Project Information Sheet

Location of Research (Name of Center)

Dear Subjects:

The Naval Medical Center in cooperation with the (State Department) and the (Name of Collaborator), is conducting a research project titled " " to study:

Your Cooperation is greatly appreciated.

Statement that this project is research:

Study Procedures - If you agree to participate, the following procedures will be performed: xxxxx
No personal identifiers will be recorded to protect your privacy.

Risks - State any risks however minimal they are whether physical or emotional.

Benefits - State specific benefit to subject or that the study may not benefit them directly.

Your participation in this study is entirely voluntary and the alternative, if you elect not to participate, there will be no penalty and you will receive standard of care medical treatment.

Confidentiality - In all publications and presentations resulting from this research study, information about you or your participation in this project will be kept in the strictest confidence and will not be released in any form identifiable to you personally.

If you have any questions regarding this research study, **you may contact (principal investigators name) at (619) telephone #**. If you have any questions about your rights as an individual while participating in a research study at the Naval Medical Center, San Diego, you may contact the **Chairman, Institutional Review Board at (619) 532-8125, or the Head, Clinical Investigation Department at (619) 532-8238**. If you believe that you have been injured as a result of your participation in this research study, you may contact the **Legal Department, Naval Medical Center, San Diego, at (619) 532-6475**.

@ * Enter SHORT TITLE; PI LAST Name, Initial; CIP #S-FY-xxx(get # from CID)

This form is yours to keep for your information. Thank you.

If you have any further Questions or Concerns, Please speak to one of the Physicians.

SIGNATURE

You are making a decision whether or not to participate in the research project above. Your signature indicates that you have had this information presented to you, have had the opportunity to ask questions about the research and your participation, and agree to participate in the study. Further, your signature indicates that you have been provided with a copy of this consent document, a Privacy Act and a copy of a document entitled, "California Experimental Subject's Bill of Rights."

SIGNATURES AND DATE SIGNED: PRINTED OR TYPED IDENTIFICATION:

_____	_____
Patient / Subject (Date)	Name / Status / Sponsor's SSN

_____	_____
Witness (Date)	Name / Grade or Rank

_____	_____
Researcher/Investigator(Date)	Name / Grade or Rank